Washington State Department of Social & Health Services
MAA Medical Assistance Administration

HEARING AID LIMITATION EXTENSION REQUEST

PROVIDER INFORMATION		
CLINIC NAME	PROVIDER	DSHS BILLING PROVIDER NUMBER
TELEPHONE NUMBER	CONTACT NAME	FAX NUMBER

CLIENT INFORMATION	
NAME	PIC NUMBER (i.e. AB-122300-SMITH-A)

SERVICE REQUEST INFORMATION
ICD 9 CODE AND DESCRIPTION
PROCEDURE CODES

ADDITIONAL INFORMATION

Please provide the following information:

- Copy of current audiogram for both ears, aided and unaided
- Copy of Baseline Audiogram (If applicable)
- A copy of the manufacturer's wholesale invoice with the model number you are ordering
- The type of hearing aid you are requesting i.e.; analog, digital, brand and model number
- The date MAA purchased last hearing device
- Currently wearing:
  ☐ Single ☐ Binaural How long?

What are the extenuating circumstances for this request?

Fax or mail to:
Medical Request Coordinator
HRSA/DMM (previously MAA)
PO Box 45506
Olympia, WA 98504-5506
Fax: (360) 586-1471